**Associates In Women's Health**
**1307 W. 3rd St.**
**Gillette, WY 82716**

**PATIENT# _____**

## PATIENT INFORMATION SHEET

**Last name: _____ First name: _____ M.I._____**

**Mailing Address: _____**

**Street Address: _____ City: _____ State: _____ Zip Code: _____**

**Home Phone: _____ Work Phone: _____ Cell Phone: _____**

**SS#: _____ Date of Birth: _____ Marital Status: M____ S____ D___ W___**

**Emergency Contact: _____ Phone: _____ Cell Phone: _____**

**Patient's Employer: _____ Occupation: _____ Phone: _____**

**Employer's Address: _____ City: _____ State: _____ Zip Code: _____**

**Email address:_____**

## SPOUSE INFORMATION

**Last name: _____ First name: _____ M.I. _____**

**Address: _____ City: _____ State: _____ Zip Code: _____**

**Phone: _____ Cell Phone: _____ Date of Birth: _____ SS#: _____**

**Employer: _____ Phone: _____**

## INSURANCE POLICY HOLDER INFORMATION IF DIFFERENT FROM PATIENT:

**Insured Party Last name: _____ First name: _____ M.I. _____**

**Address: _____ City: _____ State: _____ Zip Code: _____**

**Phone: _____ Date of Birth: _____ SS#: _____**

**Employer: _____ Phone: _____**

## INSURANCE COMPANY INFORMATION

**Insurance name: _____**

**Address: _____ City: _____ State: _____ Zip Code: _____**

**Insured's last name: _____ First: _____ Relationship: _____**

**Insurance ID #: _____ Group #: _____**

**Secondary Insurance Y or N, if yes please provide a copy of the card.**

**ADDITIONAL AGREEMENT**

**May we call you or leave a message at work: Y or N**

**May we leave a message or call you at home: Y or N**

**May we call you or leave a message on your cell: Y or N**

**Pharmacy preference: _____**

**Allergies to medications (please list):_____**

**_____**

**Financial Agreement and Authorization: I understand and agree that (regardless of my Insurance status) I am ultimately responsible to pay all fees and charges for the treatment of the person named above. I agree to pay all charges for me and members of my family when services are rendered. A finance charge of 2% per month will be added to all billing not paid when services are rendered. In the event legal action should be necessary to collect an unpaid balance, I agree to pay costs of collection including reasonable attorney fees. It is agreed that payments will not be delayed or withheld because of insurance, and all proceeds of insurance are assigned to this office, unless otherwise paid, but without the office assuming any responsibility for the collection thereof. (A copy of this is as valid as the original).**

**Signed: _____ Date: _____**

**Authorization to release information: I authorize the release to my insurance company any medical or other information needed to process my claims.**

**Signed: _____ Date: _____**

**Assignment of Benefits: I hereby assign, transfer and set over to Associates In Women's Health, PC all my rights, title and interest to my medical reimbursement benefits under my insurance policy. This includes all services provided by, or supervised by Dr. Michael L. Jones.**

**Signed: _____ Date: _____**

***Notice or Privacy Rights (HIPAA)***
***Patient Consent Form***

**I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:**

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers, who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

**I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.***

**I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.**

**I understand that I may revoke this consent in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.**

**I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.**

**Patient Name: _____**

**Signature: _____**

**Relationship to Patient: _____**

**Date: _____**

**Associates In Women's Health**
**Michael L. Jones, MD**
**1307 W. 3rd St.**
**Gillette, WY 82716**

**FINANCIAL POLICY:**

The professional services provided by this practice are for your benefit. All fees charged by this practice are your responsibility. For your convenience Associates in Women's Health accepts cash, checks, money orders, Visa, Mastercard and Discover.

**INSURANCE:**

Associates in Women's Health will bill your insurance as a courtesy; however, payment and/or payment arrangements are expected at the time services are rendered. After 60 days from the date of service the account will be treated as a self-pay account and you will be required to submit payment in full or make acceptable payments**. If you are having a surgical procedure with one of our physicians, we will call your insurance company for benefits and pre-certification requirements. Your deductible (if not already satisfied) will be required at your pre-operative appointment**. In order for us to file to your insurance company we need to be provided with complete and accurate information to avoid delays in payment so please make sure we have your current insurance information.

**YOU ARE RESPONSIBLE FOR ALL FEES NOT COVERED BY YOUR INSURANCE COMPANY INCLUDING, DEDUCTIBLES, CO-PAY AND REASONABLE AND CUSTOMARY FEE DIFFERENCES.**

Our office cannot accept responsibility for negotiating a settlement on a disputed claim. If you dispute the amount of payment made by your insurance company, you should contact your insurance carrier, your human resources department or your agent directly.

**NO INSURANCE: If you have no insurance we do require payment up front when services are rendered.**

**UNPAID ACCOUNTS:**

Patients with unpaid delinquent accounts or accounts which have been written off to bad debt or collection may be discharged from the practice for non-compliance or required to pay up front for services even if insurance is in effect.

I have read and understand the financial agreement and I agree to comply.

Patient/Parent/Guardian Signature: _____Date:_____